

CARE DIRECTIONS® *Premier*

LONG-TERM CARE INSURANCE - OUTLINE OF COVERAGE
Policy Number PRT11-336-MA-CT-601
for Individual and List Bill Sales

This Outline of Coverage describes a Partnership-Approved Long-Term Care Insurance Policy that provides Medicaid Asset Protection under



Additional Consumer Information is available by calling the State of Connecticut Partnership for Long-Term Care Information Service at 1-800-547-3443

This Policy is intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code.

Caution: The issuance of this long-term care Policy is based upon your responses to the questions on your application. A copy of your application is enclosed. If your answers are incorrect or untrue, the Company has the right to deny Benefits or rescind your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the Company at the address above.

Notice to Buyer: This Policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

COORDINATION WITH OTHER BENEFITS NOTICE: As long as this Policy remains precertified for Medicaid Asset Protection, benefits provided under this Policy may be reduced to the extent that similar benefits are payable under any other plans or programs to which you are entitled (including Medicare). Please refer to Section 7 "Limitations and Exclusions" in this Outline of Coverage for a full explanation. This provision will not reduce the Lifetime Benefit Amount payable under this policy.

1. **POLICY.** This Policy is an individual Policy of insurance, which was issued in Connecticut.
2. **PURPOSE OF OUTLINE OF COVERAGE.** This Outline of Coverage provides a very brief description of the important features of the Policy. You should compare this Outline of Coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY!**

3. **TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED.** If you feel this Policy does not meet your insurance needs, return it to us or your agent within 30 days. If you do so, we will return any premium you may have paid. We also will void your Policy from its effective date.

When we are notified of your death, we will make a pro-rata refund to your estate of any premium paid for the period beyond your death. There is no refund when the Policy is surrendered.

4. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the insurance company. Neither MedAmerica Insurance Company nor its agents represent Medicare, the federal government, or any state government.
5. **LONG-TERM CARE COVERAGE.** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services. These services must be provided in a setting other than an acute care unit of a hospital, such as a nursing facility, in the community, or in the home.

This Policy provides coverage of 100% of actual charges incurred up to the daily benefit amount that will be chosen by you at the time you apply for the policy, and will be reflected on the schedule page of the policy, if a policy is issued to you for qualified long-term care services. Coverage is subject to Policy limitations and an elimination period.

6. **BENEFITS PROVIDED BY THIS POLICY.**

- (a) **Benefit Eligibility:** To be eligible for Benefits provided by this Policy, We must receive periodic proof from a Licensed Health Care Practitioner that You are a Chronically Ill Individual. In order to be considered a Chronically Ill Individual, You must meet the following conditions:

- You need Substantial Assistance from another person to perform at least two of the Activities of Daily Living (Bathing, Dressing, Eating, Toileting, Transferring, Continence) for a period expected to last at least 90 days; or
- You need Substantial Supervision to protect you from threats to health and safety due to Severe Cognitive Impairment.

Each of the following is an **Activity of Daily Living**:

Bathing: This means washing Yourself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence: This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

- Dressing: This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
- Eating: This means the ability to feed oneself by getting food into Your body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.
- Toileting: This means the ability to go to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring: This means the ability to move into or out of a bed, chair or wheelchair.

We will work with You, Your family and Your physician and Access Agency when We need information about Your condition. The Plan of Care under Your Policy must be developed for You by an Access Agency in conjunction with You, (together with Your family or licensed Physician if You desire) and be jointly approved by the Access Agency and Us. We will review the status of Your Activities of Daily Living and cognitive function. We will use this information to make an evaluation of Your condition to determine whether You qualify or continue to qualify for Benefits under this Policy. This information may be gathered by Us or one of Our representatives. You may contact Us with any questions regarding Our determination.

The use of an Access Agency for nursing facility care and assisted living facility care is not required to qualify for benefits under this policy. Additionally, for facility care and assisted living facility care, an Access Agency is not required to develop and/or approve the Plan of Care, in order for benefits to qualify for Medicaid Asset Protection under this policy.

We must receive certification from a Licensed Health Care Practitioner at least every 12 months that you meet the above conditions.

- (b) There is a once-in-a-**Lifetime Elimination Period**, which you will have selected on the application and which will be listed in your Schedule if one is issued, for which you must pay qualified long-term care expenses for Benefits covered in this Policy.

A day is credited toward the Lifetime Elimination Period for each eligible day paid in part or in full by Medicare. Days used to satisfy your Lifetime Elimination Period do not need to be consecutive.

There is no Lifetime Elimination Period for Hospice Program, Respite Care, Caregiver Training, Care Management or Supportive Equipment Benefits. These Benefits may not be used to satisfy the Lifetime Elimination Period. If you are receiving Hospice Program Benefits paid by another insurer, we will waive the Lifetime Elimination Period.

- (c) To calculate your **Lifetime Benefit Amount**, multiply the daily benefit amount you will select on the application and which will be listed in your Policy schedule if one is issued to you, by the number of days which you have selected. We will deduct from this amount all Benefits we pay for all covered services provided under this Policy.

- (d) **Care Management:** When you are determined to be Chronically Ill, an Access Agency will develop a Plan of Care for You with assistance from You, Your family and Your physician, if requested by you. We will pay for the following Care Management services: an assessment of the need for long-term care services; the development of a Plan of Care that is consistent with the assessment; coordination of the delivery of care and services; and monitoring the care and services delivered. This Benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

The use of an Access Agency for nursing facility care and assisted living facility care is not required to qualify for benefits under this policy. Additionally, for facility care and assisted living facility care, an Access Agency is not required to develop and/or approve the Plan of Care, in order for benefits to qualify for Medicaid Asset Protection under this policy.

- (e) Qualified Long-Term Care Services must be provided by **Approved Providers** in order to be reimbursed. Approved Providers are any of the following:
- **Nursing Facility;**
 - **Assisted Living Facility;**
 - **Hospice Program;**
 - **Home Health Care Agency; or**
 - **Adult Day Care Center.**
- (f) If you meet Benefit Eligibility, we will provide Benefits at 100% of the actual charges incurred up to the Daily Benefit Amount listed in your Policy Schedule for **services provided in a Nursing Facility, Assisted Living Facility, or by an Adult Day Care** that are Qualified Long-Term Care Services.
- (g) If you meet Benefit Eligibility, we will provide Benefits at 100% of the actual charges incurred up to the Daily Benefit Amount shown in your Schedule for **services provided by a Hospice Program** that are Qualified Long-Term Care Services.

This Benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

- (h) If you meet Benefit Eligibility, we will provide Benefits at 100% of the actual charges incurred up to the Daily Benefit Amount listed in your Schedule for **services provided by a Home Health Care Agency** that are Qualified Long-Term Care Services and are:
- nursing services;
 - respite services;
 - physical, occupational, respiratory and speech therapy;
 - home health aide or personal care attendant services including such things as: personal hygiene, performing Activities of Daily Living, managing medications, and other related supportive services; or
 - homemaker services including light work, household tasks, preparing meals, doing laundry and other household tasks that do not require the services of a trained aide or attendant.

- (i) If you meet Benefit Eligibility, **Alternative Care Benefits** may be paid for Qualified Long-Term Care Services including, but not limited to, medically necessary transportation to and from Adult Day Care.
- (j) **Bed Reservation Benefits** will be paid if we are paying for Benefits in a Nursing Facility or Assisted Living Facility and that facility charges you a fee to reserve your bed. We will pay to reserve your bed for up to 21 days per calendar year.
- (k) If you meet Benefit Eligibility, **Caregiver Training Benefits** will be paid if you are at home and you, or a person designated by you and agreed to by us, requires training in the proper use and care of supportive equipment, medical aids or assistance with the performance of your Activities of Daily Living or other supportive needs.

The total Caregiver Training Lifetime Maximum Benefit that is listed in your schedule is five times your Daily Benefit Amount. Benefits paid for Caregiver Training will be deducted from your Lifetime Benefit Amount and must be included in a Plan of Care approved by a Licensed Health Care Practitioner employed by an Access Agency.

This Benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

- (l) If You meet Benefit Eligibility, We will reimburse You for expenses You pay for the rental, lease or purchase of **Supportive Equipment** that is used to provide You with Qualified Long-Term Care Services.

We will pay this benefit as outlined on Your Schedule Page of Your Policy. Benefits paid for Supportive Equipment will be deducted from Your Lifetime Benefit Amount, and must be included in a Plan of Care approved by a Licensed Health Care Practitioner employed by an Access Agency.

This benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

- (m) If you meet Benefit Eligibility and you are at Home, **Respite Care Benefits** will be paid for Respite Care provided in your Home, in a Nursing Facility, or in an Assisted Living Facility.

We will pay Benefits for up to the Daily Benefit Amount shown in your Schedule for a maximum of 30 days per calendar year. Benefits paid for Respite Care will be deducted from your Lifetime Benefit Amount. This Benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

- (n) **Worldwide Coverage** is provided to cover services by approved providers anywhere in the world.

- (o) **Medicaid Asset Protection** Benefits paid to You, or to a provider of long-term care services on Your behalf, under this Policy can count towards Medicaid Asset Protection for purposes of Medicaid eligibility for Connecticut's Medicaid program or any other state's Medicaid program that has a reciprocal agreement with Connecticut's Medicaid program. In order for benefit payments to count towards Medicaid Asset Protection, the conditions must be met.

You have met one of the following Insured Events:

- You have a documented need for Substantial Assistance with two or more of the following Activities of Daily Living: Dressing, Bathing, Eating, Toileting, Continence and Transferring; or
- You have been assessed using the Mental Status Questionnaire (MSQ) and have seven or more incorrect answers on the MSQ test, or
- You exhibit specific behavioral problems requiring daily supervision, (including but not limited to, wandering, abusive or assaultive behavior, poor judgement or uncooperativeness which poses a danger to You or others, and extreme or bizarre personal hygiene habits); and have taken either the MSQ test and have four or more incorrect answers, or have taken the Folstein Mini-Mental State Examination and achieved a score of 23 or lower.

The benefits are paid under this Partnership-approved Policy; and

The benefits that are paid for all services other than Nursing Facility and Assisted Living Facility Benefits are provided in accordance with a written Plan of Care approved by an Access Agency (the Access Agency must be approved by the Connecticut Partnership for Long-Term Care).

How to Stay Qualified For Medicaid Asset Protection Under the Partnership:

1. Each year Your Daily Benefit Amount must equal or exceed the minimum inflation – adjusted daily benefit specified by the Connecticut Insurance Department. The inflation-adjusted Daily Benefit Amount increase provided to You each year under the Compound Inflation Protection provision will allow You to keep pace with the Departments minimum requirements.
2. You must be a resident of Connecticut when You applied for and subsequently were issued this Partnership-approved long term care insurance .
3. Benefits paid for services Home and community-based services covered under this Policy, count toward Medicaid Asset Protection only when the Access Agency (the Access Agency must be approved by the Connecticut Partnership for Long-Term Care) developed and approved the written Plan of Care. Nursing Facility and Assisted living Facility care need not be approved by an Access Agency to count towards Medicaid Asset Protection. Services may be provided in Connecticut or elsewhere.
4. You can accumulate Medicaid Asset Protection wherever Your Policy pays benefits. If You need to access Medicaid to pay for Your care and You want to utilize the Medicaid Asset Protection You have earned, You must apply to Connecticut’s Medicaid program or to any other state Medicaid program that has a reciprocal agreement with Connecticut. You must be a resident of and receive care in the state where You apply to Medicaid.

The use of an Access Agency for nursing facility care and assisted living facility care is not required to qualify for benefits under this policy. Additionally, for facility care and assisted living facility care, an Access Agency is not required to develop and/or approve the Plan of Care, in order for benefits to qualify for Medicaid Asset Protection under this policy .

7. LIMITATIONS AND EXCLUSIONS.

- (a) **Pre-existing conditions:** There are no pre-existing condition limitations in this Policy.
- (b) **Exclusions:** Expenses for the following will not be reimbursed under this Policy:
- Substance abuse treatment for alcohol or drug addiction;
 - Treatment for illness or medical condition arising out of war or any act of war, declared or undeclared;
 - Services for intentionally self-inflicted injury;
 - Treatment provided in a government facility except treatment provided to a Medicaid recipient or as otherwise required by State or Federal law;
 - Services provided by a member of your family.
- (c) **Nonduplication:** We will not pay Benefits for services or expenses that are reimbursable under Medicare or under any other federal, state, or other governmental health care plan or law (except Medicaid). This exclusion also applies to services or expenses that would be reimbursable by Medicare but have been applied to a deductible or coinsurance amount.

(d) **Coordination With Other Benefits:**

The benefits of this Policy are designed to supplement not duplicate other benefits.

If You have any health insurance plan or non-Partnership long-term care plan and You are entitled to benefits under those plans that would also be covered services under this Policy, You are required to obtain coverage for those benefits first, prior to using benefits under this Policy. Examples of health insurance plans include, but are not limited to, basic hospital, health maintenance organization (HMO), medical/surgical, major medical plan, Medicare, Medicare managed care plan, and Medicare supplemental programs.

If You are eligible to receive benefits under this Policy and any other Partnership-approved long-term care plans, then the plan with the earliest Effective Date shall be deemed to be the primary coverage and the other Partnership-approved plans shall be deemed secondary coverage, in order by Effective Date, from earliest to latest.

Any benefit amounts that You are entitled to receive under this Policy will be reduced by any benefits payable by those other plans. This provision will not reduce the Lifetime Benefit Amount payable under this Policy.

**THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED
WITH YOUR LONG-TERM CARE NEEDS.**

8. RELATIONSHIP OF COST OF CARE AND BENEFITS.

Because the costs of long-term care services will likely increase over time, you should consider how the Benefits of this plan may be adjusted.

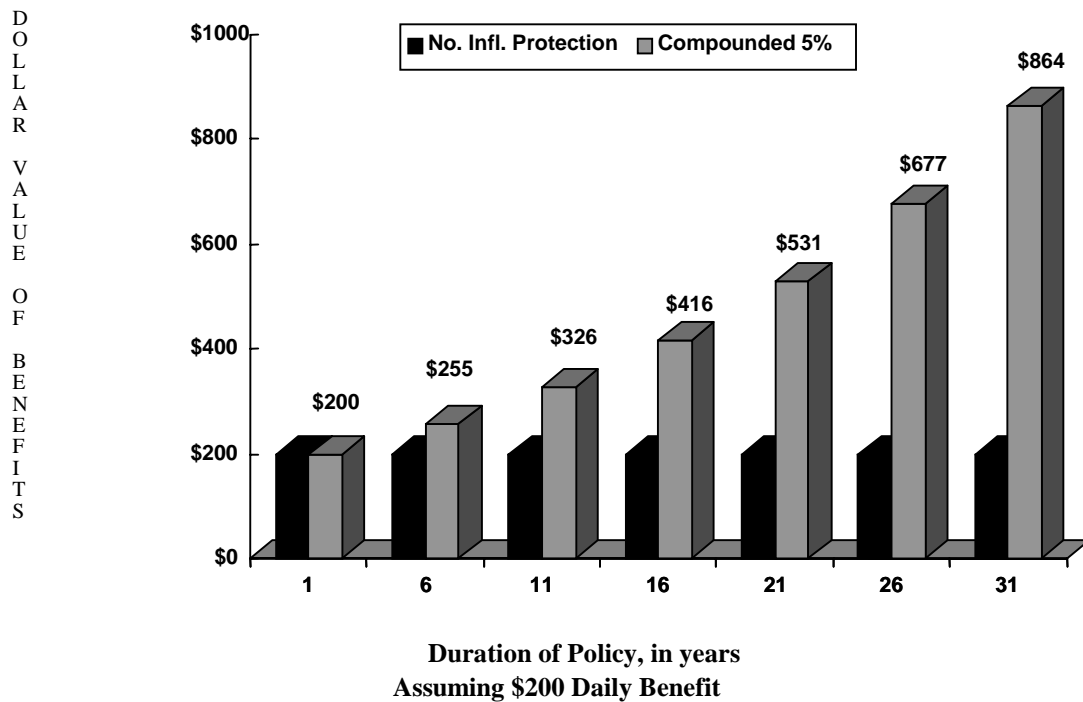
- (a) Compound Inflation Protection is **required** for all Partnership purchasers. For applicants under age 65 Inflation Protection will increase both your Daily Benefit Amount and your Lifetime Benefit Amount. Applicants age 65 and older, have the option to purchase Inflation Protection, which will increase your Daily Benefit Amount only.
- (b) Sample Benefit adjustment provisions:

If you purchase \$200 per day nursing facility coverage, the following are your Benefits over time:

Compound indexing benefits, will provide your Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of this policy. Annual increases will apply to benefits payable for any expenses you incur on or after the date of the increase. This first increase will be equal to 5% of your original amounts. Each increase thereafter will be equal to 5% of the increased amounts that applied on the date of the prior increase. Benefits increase without regard to health status.

Comparison of Daily Benefit Level with and without Inflation Protection

Compounded 5% Interest - Lifetime Duration



Premium and Lifetime Benefit Amount Comparison with and without Inflation Protection

The portion of the annual premium, which corresponds to the base policy and each benefit option, is as follows

- (1) **Base Policy** **46%**
- (2) **Inflation Protection** **54%**

POLICY A		POLICY B		
Increasing Benefits		Level Benefits		
<u>Period (Year)</u>	<u>Level Premium</u>	Indexed Benefits (5% increase per year)	<u>Level Premium</u>	<u>Level Benefits</u>
1	\$3165.20	\$219,000	\$1869.60	\$219,000
6	\$3165.20	\$280,000	\$1869.60	\$219,000
11	\$3165.20	\$357,000	\$1869.60	\$219,000
16	\$3165.20	\$455,000	\$1869.60	\$219,000
21	\$3165.20	\$581,000	\$1869.60	\$219,000
26	\$3165.20	\$742,000	\$1869.60	\$219,000
31	\$3165.20	\$947,000	\$1869.60	\$219,000

This Benefit Comparison, is based on the following:

- Issue Age 65
- 90 Day Elimination Period
- \$200.00 Per Day
- \$219,000 Lifetime Benefit Amount
- 3 Year Benefit Duration
- Lifetime Premium Payment Mode
- With and Without Inflation Protection

- (c) You may purchase additional coverage, at any time; however, after 30 days from the effective date of your Policy, this will require a new application, which will be subject to medical underwriting.

**NOTICE TO APPLICANT REGARDING
MANDATORY INFLATION PROTECTION**

In order for this long-term care insurance policy to remain Partnership-approved by the State of Connecticut and qualify to provide Medicaid Asset Protection under the State Medicaid program in Connecticut, daily coverage benefits shall meet or exceed standards established by the State of Connecticut. The Company will provide you with a graphic comparison showing the difference in premiums and benefits, over at least a twenty (20) year period, between a policy with inflation protection that increases benefits (“Policy A”), and a policy that does not increase benefits (“Policy B”). Failure to maintain the required daily coverage benefits will result in the Policy losing its Partnership-approval status and no longer being allowed to provide Medicaid Asset Protection. It is the Company’s responsibility to automatically inflate daily coverage benefit levels in order to maintain Partnership approval; it is your responsibility to make premium payments in order to maintain coverage and eligibility for Medicaid Asset Protection.

9. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

- (a) **RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means that if issued you have the right, subject to the terms of your Policy, to continue your Policy as long as you pay your premiums on time. MedAmerica Insurance Company cannot change any of the terms of your Policy on its own, except that, in the future, IT MAY CHANGE THE PREMIUM YOU PAY. All changes to the Policy and premiums are subject to approval by the Connecticut Insurance Department, where applicable.
- (b) **WAIVER OF PREMIUM.** Your premium payments will be waived on a monthly basis starting on the first day we will pay for Benefits in a Nursing Facility, Assisted Living Facility, or Hospice Program OR on the 91st day we will pay for Benefits for Home Care or Adult Day Care. Premium payments will resume on the first day We will no longer pay for Benefits as outlined in the Policy.
- (c) **OUR RIGHT TO CHANGE PREMIUM.** We can change your premium with thirty (30) days written notice, but only if we change the premiums for all policies like yours that we have issued in the state where this Policy has been approved. All changes to premiums are subject to approval by the Connecticut Insurance Department.
- (d) **STEP DOWN COVERAGE.** If Your Policy is about to lapse, We will notify You of Your right to reduce Your Lifetime Benefit Amount by lowering your Benefit Duration to reduce Your premium. You will have no less than 35 days to consider the offer. Notice will be sent 30 days after the premium is due. The premium for the new Lifetime Benefit Amount will be based upon Your age at the time Your Policy was originally issued. It will be Your responsibility to continue to promptly pay this new reduced premium before the end of each Grace Period.

The Reduced Lifetime Benefit Amount will take into account any increases in coverage that have accumulated due to the Compound Inflation Protection provision in Your Policy, along with any decreases due to claims paid.

The Daily or Monthly Benefit Amounts will not be reduced and will continue to reflect any increases in accordance with the Compound Inflation Protection provision. All other provisions in Your Policy will remain the same.

We will make such an offer whenever Your Policy is about to lapse during the first year it is in force, and at least once after the Policy has been in force for one year. We will NOT make a Reduced Benefit Option offer to You if the balance of Your Lifetime Benefit Amount (after any claims have been paid) would provide for the equivalent of one year of coverage or less.

- 10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.** Once the Policy is issued, this Policy provides coverage if you are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Coverage is contingent upon documentation by a licensed health care practitioner that you are severely cognitively impaired requiring substantial supervision. This benefit is subject to the same Benefit Eligibility provisions and Lifetime Elimination Period limitations as other benefits.

11. PREMIUM.

- (a) The total annual premium quoted for your Policy is shown below. The total premium amount of your issued Policy is listed on the Schedule page of your Policy and may vary from the amount that is identified below due to medical underwriting.
(Agent: Please use the space below to indicate the premium quoted.)

Annual Base Policy Premium	\$ _____
Spousal Discount	\$ _____
List Bill Discount	\$ _____
Shortened Benefit Period Rider	\$ _____
Enhanced Return of Premium Rider	\$ _____
Return of Premium Nonforfeiture Rider	\$ _____
Spousal Benefit Transfer Rider	\$ _____
Survivorship Benefit Rider	\$ _____
Restoration of Benefits Rider	\$ _____
Monthly Home Health Care Benefit Rider	\$ _____
Total Annual Premium	\$ _____
Semi Annual Premium \$ _____	Quarterly Premium \$ _____
Monthly (Credit Card or Bank Account Draft Only) Premium \$ _____	

- (b) If a policy is issued, an initial grace period of 30 days will be granted for each premium that is unpaid on the date due. After 30 days, a notice will be sent to you explaining that a payment has been missed and that your Policy risks lapsing. If you have designated an individual to be notified of lapse, We will send notice to the address you provided for that designee. You will have an additional 35 days from the date we mail notice to you during which any unpaid premium must be paid. Payment will allow your Policy to continue in force without interruption. Failure to pay any unpaid premium by the end of this Grace Period will result in the termination of your Policy as of the premium due date.
If you have designated an individual to be notified of lapse, we will provide you the opportunity, no less frequently than every 2 years, to change such designation.

13. ADDITIONAL FEATURES.

- (a) Medical underwriting of your application is used to determine your eligibility for long-term care insurance and to determine your correct Rate Group classification.
- (b) Benefits may be available after termination if you are receiving benefits covered under the Policy. See the “Extension of Benefits” section of your Policy for specific requirements.
- (c) If your Policy terminates because of non-payment, you may apply for reinstatement of the Policy.
- (d) No prior hospitalization or institutionalization is required before you can receive coverage for services under this Policy.

(e) **Shortened Benefit Period Nonforfeiture Rider**

If you purchase this Rider, the following Benefit applies:

Shortened Benefit Period Nonforfeiture Benefit

We will continue the coverage provided by this Policy, subject to a reduced Lifetime Benefit Amount, if your coverage under this Policy has been in force for three years or more and your coverage lapses due to cancellation or nonpayment of premium. This reduced Lifetime Benefit Amount is called your Nonforfeiture Maximum Benefit. If the eligibility requirements are met, we will provide Benefits at 100% of the actual charges incurred for any Qualified Long-Term Care Services, otherwise covered under your Policy, up to your Nonforfeiture Maximum Benefit.

Amount of Benefit

Your Nonforfeiture Maximum Benefit will be the greater of:

1. The sum of all premiums paid for your coverage under this Policy and any attached Riders;
or
2. Thirty (30) times the Daily Benefit Amount in effect on the date your coverage under this Policy lapses.

However, your Nonforfeiture Maximum Benefit will never be greater than your Policy Lifetime Benefit Amount at time of lapse.

(f) **Enhanced Return of Premium Rider**

If you purchase this Rider, the following Benefit applies:

Upon notification of Your death, We will refund to your estate all premiums paid for Your Policy and any Riders less any Benefits paid or payable. The amount of the refund is determined by calculating the total sum of premiums paid and reducing that amount by (A) and (B):

- (A) = Any premiums which were waived and any unearned premiums refunded at Your death.
(B) = Your total benefits paid or payable.

(g) **Return of Premium Nonforfeiture Rider**

If you purchase this Rider, the following Benefit applies:

Upon notification of your death, we will refund to your estate a portion of the premiums paid less any Benefits paid or payable. The amount of the refund is determined by multiplying (A) by (C) and then subtracting (B). (A), (B) and (C) are defined as follows:

(A) = Your total premiums paid, for your policy and riders, not including any premiums which were waived, less any unearned premiums refunded at your death.

(B) = Your total Benefits paid or payable.

(C) = The applicable factor from the Schedule of Factors shown below. It is determined based on your age on the birthday preceding the date of death.

Schedule of Factors

Age of Insured at Death	Factors
65 or younger	100%
66	90%
67	80%
68	70%
69	60%
70	50%
71	40%
72	30%
73	20%
74	10%
75 or older	No refund is made

The factors shall be further reduced on a monthly basis for each attained month of age preceding the date of death.

(h) **Spousal Benefit Transfer Rider**

If you and your spouse (or domestic partner) each purchase one of these Riders, the following Benefits apply:

Spousal Benefit Transfer Rider Benefit

When you and your spouse each purchase a Spousal Benefit Transfer Rider, you are increasing the Lifetime Benefit Amount each of you would be entitled to use when qualifying for Benefits payable under your Policy. By purchasing the Riders, you are agreeing to accomplish this by first using your own Lifetime Benefit Amount and then, at the option of your spouse, using a portion or all of your spouse's Lifetime Benefit Amount.

Benefits will be charged against your Lifetime Benefit Amount until it is exhausted and then they will be charged against your spouse's Lifetime Benefit Amount.

Both Policies and both Riders must remain in force for the provisions to be in effect.

Surviving Spouse Benefit

If one spouse dies when both Policies and Riders are in force, the surviving spouse will inherit the total remaining combined pool of Lifetime Benefit Amounts, subject to any increases due to the Compound Inflation Protection provision in the Policy. The surviving spouse will be responsible for continuing only his or her own Policy premium and Rider premium payments. If the surviving spouse cancels the Rider at any time, he or she will be entitled only to the Benefits which remain unused under his or her own Policy.

Discontinuation of Rider and/or Lapse of Base Policy

Either spouse may choose at any time to maintain his or her Policy and discontinue the Rider or to discontinue both the Policy and the Rider. Please note that these changes will affect you in the following ways:

1. You must agree that, if one spouse cancels the Rider, the Rider for the second spouse is automatically cancelled. In this instance, both spouses can retain their Policies, and each pays his or her original premium amount. Each spouse retains his or her own remaining Lifetime Benefit Amount.
2. You must agree that, if one spouse cancels both the Policy and Rider, the Rider for the second spouse is automatically cancelled. The second spouse can retain his or her Policy and pay the original premium amount. The spouse retaining the Policy will retain his or her own remaining Lifetime Benefit Amount.

Benefit Transfer Purchase Requirements

1. At the time you apply for your Policy, you and your spouse must agree to make the same selections of benefit features (Daily Benefit Amounts, Lifetime Benefit Amounts, Inflation Protection Features and Riders) and payment terms. You must also agree to have the same effective date of coverage if both of you are accepted and issued a Policy.

2. You agree to accept the fact that if your spouse uses his or her total Policy Benefits and then accesses your Benefits, you will have fewer Benefits available to you than you would have had under your own Policy if you had not purchased this Rider.

Impact On Medicaid Asset Protection When A Policy Covers Both You and Your Spouse.

1. If one spouse is accessing benefits under this Spousal Benefit Transfer Rider, the other spouse will not receive Medicaid Asset Protection for that care. Medicaid Asset Protection is not transferable between spouses. In addition, continued access by one spouse to this Rider's benefits could lead to the exhaustion of the Policy's Lifetime Benefit Amount for both spouses' policies. In such an event this Rider and both policies will terminate and neither spouse will earn additional Medicaid Asset Protection.

(i) **Survivorship Benefit Rider**

If you and your spouse each purchase one of these Riders, the following Benefit applies:

Benefit

We will not require the payment of premium under this Policy after both of the following events have occurred:

- Your Policy and your spouse's Policy have been in force with us for ten consecutive years; and
- Your spouse is deceased.

Discontinuation of Rider and/or Lapse of Base Policy

You may choose at any time to discontinue both your Policy **and** this Rider, **or** to discontinue **only** this Rider. The following conditions apply:

1. If you cancel this Rider, your spouse's Rider is automatically cancelled. You and your spouse each have the option to retain your base Policies.
2. If you cancel both your base Policy and this Rider, your spouse's Rider is automatically cancelled. Your spouse can retain his or her base Policy.
3. Your Rider and your spouse's Rider are automatically cancelled as of the date of a divorce or a legal separation.

Survivorship Purchase Requirements

At the time you apply for your Policy, you and your spouse must agree to purchase the same benefit features. These benefit features include: the Daily Benefit Amount, Lifetime Benefit Amount, any options and Riders.

Both you and your spouse must also agree to purchase this Rider and choose the same payment terms. The effective date of both Policies must also be identical.

(j) **Restoration of Benefits Rider**

If you purchase this Rider, the following Benefit applies:

We will restore this Policy's Lifetime Benefit Amount to the amount that would have applied if no Benefits had been paid under this policy. This Restoration of Benefits applies whenever a period of 180 consecutive days elapses in which:

- You were not eligible for or being paid for Benefits; and
- Your Policy did not lapse and all premiums were paid; and
- You have not reached your Lifetime Benefit Amount; and
- Your Policy is currently in force.

(k) **Monthly Home Care Benefit Rider with Enhanced Waiver of Premium.**

If you purchase this Rider, the following Benefit applies:

This rider provides for payment of a monthly home care and adult day care benefit. The maximum amount payable for this benefit is 100% of the actual charges incurred in a calendar month up to the number of days in that calendar month times the Daily Benefit Amount shown in Your Schedule subject to the lifetime elimination period. This rider also replaces your premium waiver benefit provided in the policy by the following:

- On the first day of policy-paid services in a Nursing Facility, Assisted Living Facility Hospice Program, or;
- After an amount equal to thirty (30) times your daily benefit amount for Home Care or Adult Day Care services has been paid.